# Project to Improve the Model Evidence of Coverage (EOC) Document—Phase 2: Results from Final Rounds of Consumer Testing of the Revised Evidence of Coverage

**Purpose:** Medicare+Choice (M+C) organizations are required by law to send an Evidence of Coverage (EOC) document to new members upon enrollment and to all members each year. The EOC gives details about benefits and services and how to use the plan. CMS has developed a model EOC template that contains the type of information it expects in an EOC and the manner in which it prefers this information to be presented. Though M+C organizations aren't required by law to follow the model, those that do by law receive an expedited 10-day review of their EOC document by CMS. Two phases of consumer testing were done, focusing on revising particular sections of the EOC. In each phase, multiple rounds of testing were done to test the revised versions and make further improvements.

**Results:** This report summarizes the results from Phase 2 of the consumer testing of the EOC. Phase 2 consisted of developing additional mockups of the EOC based on stakeholder feedback on earlier revisions. The mockups were then consumer-tested, revised further, and re-tested using 39 individual interviews with consumers in two cities. Key findings from the consumer testing were as follows:

1. General Impressions of the EOC

- Initial Reactions to the EOC Mockup:

  - In general, respondents liked the EOC mockup and found it to be understandable and straightforward, especially in comparison to EOCs they recalled receiving in the past.

  - For the most part, people (including some of the less skilled readers) were able to use the document, experiencing major difficulties in only a few areas.

  - Some people said they preferred to call and talk with a customer service representative than to read a booklet.

  - Several respondents said they liked how the booklet gave definitions of of words and gave details in sections of the booklet, such as rights and responsibilities and prescription drugs.

  - While people were generally able to understand the EOC mockup, it contained some terms and topics (e.g., “Original Medicare,” “benefit period”) that are inherently complex and hard to convey in simple

language.

- Topics of Greatest Personal Interest to Respondents (based on their initial comments while looking at the EOC cover and Table of Contents):

  ▪ What enrollees must pay (premiums, co-payments, etc.);

  ▪ Prescription drug benefits;

  ▪ Emergency care;

  ▪ What is covered during travel outside of home geographic area; and

  ▪ Information on primary care providers.

- Similar to the findings from Phase 1 of the consumer testing, most participants during Phase 2 were unfamiliar with at least some of the information they read about in the EOC mockup.

  ▪ People tended to be unfamiliar with or misinformed about a number of the terms pertaining to the prescription drug benefit (e.g., “formulary,” “generic drugs,” “benefit limit”); and they were unfamiliar with their beneficiary rights.

  ▪ People also tended to have problems with certain terms and concepts that are problematic for beneficiaries, including “Original Medicare,” “Medicare managed care plans,” and the differences between “urgent” and “emergency” situations.

- There was a goodly amount of variation in how respondents approached the task of reading the mockup and how they were able to understand the information it contains.

  ▪ Many factors were involved, including the degree of interest in the EOC, reading skills and habits, and knowledge and attitudes about Medicare and managed care.

  ▪ Some people said they preferred to get information by talking to someone rather than (or in addition to) reading a booklet like the EOC.

  ▪ In general, participants with more formal education tended to have better reading skills and more accurate and extensive background knowledge, although there were some exceptions to this.

  ▪ Overall, most participants were able to understand most of what they read, provided they read all of it carefully; and they could generally find

what they were looking for unless they misunderstood the words or concepts.

- ▪ As in Phase 1 of the consumer testing, some people made comments during Phase 2 that reflected feelings of vulnerability, intimidation, or concern, while other comments reflected doubt or cynicism about certain topics (such as legal matters).

- ▪ However, some of the comments reflected peoples' pleasure or reassurance about learning something new, such as some of the information about their rights or resources listed in Section 1 that included information about SHIPs and Medicaid).

2. Features that Helped and Hindered Navigation through the EOC

- Most of the interview respondents were able to understand and use the Table of Contents with relative ease—in fact, the Table of Contents was the first place they turned to when searching for answers not immediately found in the section they were being tested on.

  - ▪ However, participants with limited reading skills tended to have a lot of problems navigating through the booklet, typically flipping though the pages to look for information instead of using the Table of Contents to look up topics and page numbers.

- Headers worked better than footers as a navigational tool, because the header was more prominent and seemed to work better in attracting the respondents' attention.

  - ▪ The footer did not work very well as a navigational tool because many participants did not seem to notice or use it as they read through the document.

  - ▪ Even though headers worked better than footers, many people in the final round of testing continued to flip through the pages to look for information instead of using the headers or other navigational tools.

- For some people, unfamiliarity with the concept of an "Appendix" was a big barrier to navigation.

  - ▪ They were unfamiliar with the word and concept, and did not know that an appendix is always at the end of a document.

  - ▪ Consequently, they were lost and confused when they encountered a reference to any part of the Appendix.

- ▪ As a result of this finding, revisions were made after the final round of testing that kept the appendices at the end of the document but deleted the word “Appendix” and changed the four parts of the appendix into numbered sections.

- Several of the less skilled readers had a lot of difficulty when they encountered references to other sections of the EOC.

  - ▪ A few people became completely discouraged at being told to look in another part of the booklet.

  - ▪ In some cases, the difficulty appeared to be lack of familiarity with the concept of reference to another section and the conventions used to indicate one (such as “See Section X for…”).

  - ▪ People also seemed to react negatively to references sending them to other sections, if they couldn’t see any reason for the references, or when they had little idea about the information they would find if they turned to the other part of the booklet.

- People had mostly favorable reactions to the brief list of main topics (i.e., the content summary) that appeared at the beginning of each section.

  - ▪ Several readers said the content summaries were helpful, while some others thought the summaries were “excessive” or unnecessary.

3. Reactions to the Table of Contents

   - People liked many features of the longer, detailed version of the Table of Contents.

     - ▪ Respondents noticed and appreciated the level of detail that was included in the Table of Contents.

     - ▪ They also commented favorably on the use of bolding to emphasize key terms.

     - ▪ Respondents liked having the acronym “PCP” (Primary Care Physician) spelled out for them and suggested that the same be done for other acronyms, such as “CMS” and “SHIP” that appeared in the Table of Contents.

   - Overall, when respondents were asked to compare the short and long versions of the Table of Contents, they strongly favored the longer version, saying that it was easier for them to use.

- Respondents also liked the more detailed version of the Table of Contents listing for the Appendix, compared to the shorter version that was tested.

  ▪ They favored the longer version as being more informative and more efficient, since it allowed them to easily identify what topics were covered without having to turn and look to the back of the EOC.

  ▪ The title for Appendix D was expanded to include a definition of "advance directives," since virtually no one knew that this term had to do with the more familiar terms "living will" and "power of attorney".

- Results from Round 1of the testing showed that some people expected and preferred to see the section on benefits exclusions listed in the Table of Contents right after listing the section about the benefits chart—and the Table of Contents was revised accordingly prior to Round 2.

4. Reactions to Phase 1 Testing of Section 2: "Getting Started as a Member of Maple Health Plan"

   - Note: "Maple Health Plan" was the fictional name used for testing the EOC mockup.

   - Overall, people felt that Section 2 outlined the basics of membership in Maple Health Plan well, and they seemed able to understand the key points reasonably well, despite problems with certain concepts and terminology discussed below.

     ▪ Most respondents liked having the sample plan membership card as a reference in the booklet, and seemed to understand how their Maple Health Plan member card was different from the red, white, and blue Medicare card.

   - Many people had problems understanding certain key terms and concepts, such as "Medicare managed care plan," and tended to be unclear about the relationship between Maple Health Plan and the Medicare program.

     ▪ People interviewed understood the term "Medicare HMO" better than "Medicare managed care plan;" and the revised mockup tested in Round 2 used the phrase "Medicare HMO" in place of "Medicare managed care plan."

     ▪ In general, the people who were interviewed did not seem to conceive of "their Medicare" as a package of benefits and services that could be provided in a number of different ways, but more as a specific program in which they participate.

- However, in spite of the tendency to compartmentalize “Medicare” and “HMO,” people did not necessarily believe that they would lose Medicare-covered services by being a member of a Medicare HMO.

- The term “Original Medicare” was often unfamiliar and confusing.

  ▪ Despite the prominent use of the term “Original Medicare” in such key information materials as *Medicare & You,* most of the people interviewed in this study were unfamiliar with this term.

- People were more familiar with the term “Medicare supplemental policies” than the term “Medigap.”

- Overall, people liked seeing the sample plan member card (i.e., the sample Maple Health Plan member card) in the booklet, but results from Round 1 testing showed that the sample card itself needed some fine-tuning.

  ▪ In Round 1, a few people took the sample card too literally, as representing an actual card rather than as a generic sample to show what the card looks like.

  ▪ The sample card was changed for Round 2 of testing to make it look more like a generic sample card.

5. Reactions to Section 3: “Getting the Care You Need, Including Some Rules You Must Follow”

   - Overall, the people who were interviewed seemed to understand the main points in Section 3 with relative ease.

     ▪ As discussed below, when people did have trouble with this section, it was generally related to their unfamiliarity with or confusion about a few key terms that are related to managed care.

   - Although most people seemed to understand the basic definition of a “provider,” the term “plan providers” (as well as “non-plan providers”) was challenging for a number of people interviewed.

     ▪ Some people had no sense of the business relationship between a health plan and its providers.

   - The term “covered services” was generally understood and worked quite well for nearly everyone interviewed.

- Section 3 included information about the role of a PCP (Primary Care Physician), the need to choose one, and the provider directory as a resource for members; and respondents appreciated having the term "PCP" defined multiple times.

- Most respondents had a concrete sense of what a "provider directory" was, often mentioning unprompted that it was the "list of doctors" that members of Maple Health Plan must choose from.

- Despite the vagueness of certain words or phrases that troubled some respondents, most people understood the summary of beneficiary rights that appeared in Section 3.

- While a few people said that "self-refer" was a new word to them, it appeared to be sufficiently self-explanatory, especially within the context of the section it appeared.

- While the term "service area" was unfamiliar to many people interviewed, they seemed to understand the definition and general concept of a "service area" fairly well.

  ▪ However, several people equated "being outside of the plan's service area" with being out of state or with long-distance travel.

6. Reactions to Section 4: "Getting Care if You Have an Emergency or Urgent Need for Care"

   - Results from Round 1 of testing revealed that a number of people had trouble distinguishing between what would constitute an "emergency" and what would be considered "urgently needed care."

     ▪ As a result of these Round 1 findings, revisions were made to parts of Section 4 that define "urgently needed care" and explain the coverage that applies if it turns out that a certain situation was not really an "emergency" but an "urgently needed care" situation instead.

   - Results from Round 1 of testing revealed that several readers overlooked the sentence that discussed circumstances under which ambulance services are covered by the plan.

     ▪ Revisions done before Round 2 of testing drew more attention to this topic by making the sentence into a bullet and bolding the word "ambulance."

7. Reactions to the Section about Member Rights and Responsibilities

    - The model EOC contains a separate section on member rights and responsibilities that was tested in Round 1 only.

    - Overall, participants were pleased by what they read in this section.

    - Most people interviewed were not bothered by the repetition of the phrase "you have a right" in this section; in fact, a number of them said they liked it.

    - Reactions to Specific Rights and Terminology in Section 5:

        ▪ Several respondents singled out the right to language interpretation services as important information; and one person felt it deserved more emphasis.

        ▪ Many respondents commented favorably on the right to confidentiality of medical records and personal health information and on the right to get full information about treatment choices and to participate in decisions about their care.

        ▪ Several people were pleased to read about their right to get a copy of their own medical records.

        ▪ Respondents also noticed the "advanced directive" information and were pleased to see a definition of it in this section.

8. Reactions to the Section with the Benefits Chart

    - Many of the people interviewed were confused about one or more of the bullets that list the requirements that apply to covered services.

        ▪ The term "Medicare coverage guidelines" was unfamiliar and unexplained.

        ▪ Other bullets caused problems for some respondents, due in part to confusion about the meaning of the terms "medically necessary," "preventive care," and "screening test."

        ▪ A couple people were confused by the last bullet, which reads, "With few exceptions, covered services must be provided by plan providers, or approved in advance by plan providers, in order to be covered."

- In response to a part of this section that explained possible changes in benefits during the calendar year, several people were particularly confused by language that dealt with prescription drug benefits.

  ▪ Several respondents concluded incorrectly that the prescription drug benefit could not be decreased during the year.

  ▪ One person felt that specifics on changes to the drug formulary were buried in the paragraph and easy to miss.

  ▪ Another person misunderstood the statement, “Except for the drug formulary, we cannot *decrease* your benefits during the calendar year,” thinking it meant that the drug formulary could not be changed in a way that would result in a decrease in drug benefits.

  ▪ The passage was also hard to understand for people who were unfamiliar with the term “formulary” and its meaning.

- The order in which the covered benefits were listed in the benefits chart made it difficult for people to find information about specific services.

  ▪ Several respondents looked to see whether the covered services were listed alphabetically (they are not), and were frustrated at not being able to figure out the system.

  ▪ People typically searched through the chart by flipping through the pages instead of referring back to the Table of Contents.

  ▪ Although people who read the chart were generally able to figure out the information on co-payments and deductibles for a particular row of services, the services themselves confused or sidetracked people at times—especially the chart sections on “Drugs that are covered under Original Medicare” and the “Maple Health Plan Prescription Drug Benefit,” where the names of services sounded highly technical or were difficult to pronounce.

- Respondents—even the most sophisticated readers—tended to be confused by the definition of “benefit period” that appears in this section and other parts of the EOC booklet.

  ▪ The most confusing part of the definition seemed to be the description of when the benefit period ends: “The benefit period ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor an inpatient of a skilled nursing facility (SNF).”

9. Reactions to the Section on Prescription Drugs and the Rows in the Benefits Chart that Tell about Coverage for Drugs

- Note: Since the prescription drug benefit is an optional benefit, and since the way this benefit is structured differs greatly among the M+C plans that offer it, the EOC that was prepared for Round 2 consumer testing allowed for many variations in the most common features, including use of a formulary, distinctions between generic and brand-name drugs, multiple levels of co-payments and/or coinsurance that include mail-order options, and a benefit maximum that can be applied for different time periods and for different categories of drugs.

- Overall, the people who were interviewed liked the way this section described the prescription drug benefit; and a number of them commented that it was easy to read and understand.

  ▪ Some people who had prescription drug coverage through their own plan said the EOC mockup was easier to understand than the materials they had received about their own drug benefit.

  ▪ The one major area of confusion had to do with drug coverage under Medicare: As discussed below, most people interviewed did not think of Original Medicare as covering any drugs, and were surprised and confused to see information about this in the benefits chart and in the introduction to the section on prescription drugs.

- People were confused by the distinction between drugs covered by Original Medicare versus the plan's prescription drug benefit.

  ▪ Results from both rounds of testing showed that the concept of drugs covered under Original Medicare, which appears in both the benefits chart and the introductory part of the section on prescription drugs, was difficult for people to understand.

  ▪ As mentioned earlier, one reason for the confusion is because the term "Original Medicare" was unfamiliar to many people interviewed.

  ▪ However, the main reason for the confusion was that when people interviewed thought of "drug coverage," they automatically tended to envision *outpatient prescription drug coverage* rather than the type of drug coverage provided under Original Medicare, which consists largely of drugs administered during a hospital stay and a few outpatient cancer drugs.

- Reactions to Terminology in the Benefits Chart Information about Drug Coverage:

- In addition to confusion over drug coverage under Original Medicare, respondents considered terms, such as “clotting factors,” “hemophelia,” “immunosuppressive drugs,” “antigens,” and “erythropoietin,” to be technical, unfamiliar, and/or difficult to pronounce.

- The term “biologicals” was dropped from the benefits chart after Round 1 of testing; and the revised wording that was tested in Round 2 included the definition of “biologicals” without using the term itself.

- In contrast to “biologicals” above, most respondents liked having both the term “durable medical equipment” and its definition appearing in the benefits chart.

- Some people understood the word “outpatient” immediately, while others did not.

- Results from testing the language in the benefits chart showed that sometimes it does not work to replace a difficult word with a simpler one.

  - The text in Round 1 used the simpler words “given by health professionals” and “taken by patients on their own” in place of the words “administered by health professionals” and “self-administered by patients.”

  - However, reactions from respondents showed that the word “given” was too ambiguous for accuracy in this context, even though it was easier for people to read and understand.

  - Some people interpreted “given” as meaning “handed to,” and one person thought it meant that the drug was provided for free.

  - Thus, the revised text that was tested in Round 2 replaced the ambiguous simpler words with the more precise words “administered by health professionals” and “self-administered by patients.”

- People’s reactions to the layout of the benefits chart revealed some problems with navigation.

  - For example, in Round 1, some people failed to connect the description of benefits on the left side of the table with the information about cost sharing on the right side; the alignment on both sides was too subtle a cue.

- Reactions to Terminology and Concepts in the Section on Prescription Drug Benefits:

▪ The term “formulary” was unfamiliar and confusing to many people.

- An explanation of “formulary” was added, which most people found helpful allowing them to reach a fairly good understanding of the concept.

- The revisions after the last round of testing generally used the term “formulary list” instead of “formulary.”

▪ The section on prescription drug benefits included an explanation about “brand-name” and “generic” drugs, which respondents found helpful.

- For instance, before one respondent read through the section, he thought that generic brands of drugs were impure and that brand-name drugs were pure—but after reading the definition, he learned that drug type does not reflect its purity or effectiveness.

▪ Most people who read the co-payment explanation carefully were able to figure out how much the co-payments would be under certain circumstances.

- A few people had trouble understanding how the mail-order service worked and how much drugs would cost if they got them through this service.

▪ After reading the explanation about a yearly limit on prescription drug benefits, respondents generally understood that there was a dollar amount limit on the prescription drug benefit.

- However, when interviewers gave examples that required the respondents to apply their understanding of how the yearly limit worked, a number of people were either unclear or mistaken about which dollars actually counted toward the yearly limit.

▪ Overall, respondents found to be very helpful a diagram in this section that shows how “your co-payment” plus “Maple Health Plan’s payment” equals the “total cost” of the prescription (i.e., the amount agreed upon by Maple Health Plan and the plan pharmacies).

▪ Most respondents were able to explain what would happen if they reached their yearly drug benefit limit, or fell short of the limit, before the end of the year.

- Several people thought it was too burdensome to expect people to keep track of where they stood in terms of how much of their benefit

limit was left.

- Some thought that the booklet should have a phone number they could call at any time to find out how many dollars remained in their benefit.

10. Reactions to the Sections about Hospital Care, Skilled Nursing Facility Care, and Other Services

- The only issue that arose was confusion about how the "benefit period" is defined.

  ▪ This problem was noted above in the discussion of people's reactions to the benefits chart.

11. Reactions to the Summary List at the Beginning of the Section about Payment for Coverage and Care

- The summary list on the first page of this section was dropped during revisions to the model EOC after testing was completed.

- While some of the respondents readily understood that the first page was just a summary list, most thought it was unnecessary and distracting.

- Testing showed that many people tended to skim quickly over the summary list on the first page rather than reading it closely.

  ▪ Especially among those who skimmed, many respondents missed the point that the first page was a list of key points discussed in this section.

- Less-skilled readers tended to have trouble linking a summary point on the first page to its corresponding discussion later in the section.

12. Reactions to the First Part of Section 11: "Appeals and Grievances: What to Do if You Have Concerns or Complaints"

- This section had been rewritten to clarify some areas of confusion that were identified in the Phase 1 testing.

- Respondents during Phase 2 testing had positive reactions to the overview about appeals and grievances, and demonstrated that they understood the text without difficulty.